AMENDED IN ASSEMBLY JULY 6, 1998

AMENDED IN ASSEMBLY JUNE 9, 1998

AMENDED IN ASSEMBLY JULY 17, 1997

AMENDED IN ASSEMBLY JUNE 30, 1997

AMENDED IN SENATE MAY 19, 1997

AMENDED IN SENATE MARCH 31, 1997

# SENATE BILL No. 956

**Introduced by Senator Rosenthal**

February 27, 1997

An act to add Section 1348 to the Health and Safety Code, and to amend Sections 1872.85 and 1872.9 of the Insurance Code, relating to insurance.

LEGISLATIVE COUNSEL'S DIGEST

SB 956, as amended, Rosenthal. Insurance fraud.

(1) Existing law provides for the regulation of health care service plans by the Department of Corporations. A willful violation of these provisions by a health care service plan is a crime.

This bill would require every health care service plan to establish an antifraud plan, as specified, which would be required to be submitted to the department no later than July 1, 1999. The bill would ~~require~~ *authorize* the Commissioner of Corporations to adopt regulations to provide guidance on minimum standards of compliance in this regard.

Because a willful violation of these provisions by a health care service plan would be a crime, this bill would impose a state-mandated local program by creating new crimes.

(2) Existing law provides for the creation of the Bureau of Fraudulent Claims in the Department of Insurance, and requires every admitted disability insurer or other entity liable for any loss due to health insurance fraud to pay an annual fee as determined by the Insurance Commissioner, not to exceed 10¢ annually for each insured in order to fund increased investigation and prosecution of fraudulent health insurance claims. Existing law requires the commissioner to allocate 50% of available funds to the bureau, with the remaining 50% to be allocated to district attorneys according to population.

This bill would instead require an annual fee not to exceed 50¢ per insured person, including any covered dependent, *would* provide that the maximum cumulative amount of fees collected from all insurers or other entities under this section shall not exceed $1,500,000 during any fiscal year, and *would* provide for the deposit of these fees into a newly created Health Insurance Fraud Account in the Insurance Fund. *It would exempt from these requirements accident-only, specified disease, hospital indemnity, medicare supplement, and long-term care health insurance policies.* The bill would authorize the commissioner, upon appropriation of the funds by the Legislature, to distribute up to 50% of the available funds to district attorneys, with the remaining funds to be distributed to the bureau.

The bill would enact other related provisions.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

SECTION 1. Section 1348 is added to the Health and Safety Code, to read:

1348. (a) Every health care service plan licensed to do business in this state shall establish an antifraud plan. The purpose of the antifraud plan shall be to organize and implement an antifraud strategy to identify and reduce costs to the plans, providers, subscribers, enrollees, and others caused by fraudulent activities, and to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud. The antifraud plan elements shall include, but not be limited to, all of the following: the designation of, or a contract with, individuals with specific investigative expertise in the management of fraud investigations; training of plan personnel and contractors concerning the detection of health care fraud; the plan's procedure for managing incidents of suspected fraud; and the internal procedure for referring suspected fraud to the appropriate government agency.

(b) Every plan shall submit its antifraud plan to the department no later than July 1, 1999. The submission shall describe the manner in which the plan is complying with subdivision (a) and the name of a contact person who will be responsible for communicating with the department and the local district attorneys on matters related to health care fraud. The name of the contact person shall not be made part of the public record.

(c) The commissioner may adopt regulations to implement this section to provide guidance on the minimum standards of compliance.

SEC. 2. Section 1872.85 of the Insurance Code is amended to read:

1872.85. (a) The commissioner shall ensure that the Bureau of Fraudulent Claims aggressively pursues all reported probable incidents of health insurance fraud, as defined in Sections 549 and 550 of the Penal Code, and as prohibited by those sections and any other provision of law.

(b) Every admitted disability insurer or other entity liable for any loss due to health insurance fraud doing business in this state shall pay an annual fee to be determined by the commissioner, but not to exceed fifty cents ($0.50) annually for each insured person, including any covered dependents, under an individual or group insurance policy it issues in this state. The maximum cumulative amount of fees collected from all insurers or other entities under this section shall not exceed one million five hundred thousand dollars ($1,500,000) during any fiscal year. The fees collected shall only be used to fund increased investigation and prosecution of health insurance fraud. *This section shall not apply to accident-only, specified disease, hospital indemnity, medicare supplement, or long-term care health insurance policies.*

(c) The amount collected pursuant to subdivision (b), together with the amount of any fines collected for violations of law related to health insurance fraud, shall be deposited in the Health Insurance Fraud Account, which account is hereby created in the Insurance Fund. The department may receive funds from the account for its incidental expenses associated with the collection of the fee, upon appropriation by the Legislature. The remaining moneys in the account shall be expended, upon appropriation by the Legislature, only for health insurance fraud investigations and prosecutions as provided in this section. Funds in the account shall not be transferred to the General Fund or expended for any other purpose. Any appropriated funds not expended in any fiscal year shall be placed in a reserve and shall be available, upon appropriation, for expenditure, as provided by this section, in a future fiscal year.

(d) After incidental expenses, the remaining funds in the account shall be distributed to the Bureau of Fraudulent Claims of the department for investigative and prosecutorial efforts. The commissioner may distribute up to 50 percent of the funds to local district attorneys for investigation and prosecution of health insurance fraud cases.

(e) The Bureau of Fraudulent Claims shall forward to the appropriate disciplinary body the names of any individuals licensed under the Business and Professions Code who are convicted of engaging in fraudulent activity along with all relevant supporting evidence.

SEC. 3. Section 1872.9 of the Insurance Code is amended to read:

1872.9. The Bureau of Fraudulent Claims shall annually compile and report, as a part of the commissioner's annual report as required by Section 12922, the following information:

(a) The number of cases reported to the bureau pursuant to this chapter.

(b) The number of cases rejected for which an investigation was not initiated by the bureau due to insufficient evidence to proceed and the number of cases rejected for which an investigation was not initiated by the bureau due to any other reason.

(c) The number of cases that were prosecuted in cooperation with licensing agencies governed by the Business and Professions Code.

(d) The number and kind of cases prosecuted as a result of moneys received under Section 1872.7.

(e) An estimate of the economic value of insurance fraud by type of insurance fraud.

(f) Recommendations on ways insurance fraud may be reduced.

(g) A summary of the bureau's activities with respect to pursuing a reduction of fraud with all of the following:

(1) Insurance companies.

(2) The Department of Motor Vehicles.

(3) The Department of the California Highway Patrol.

(4) Licensing agencies governed by the Business and Professions Code.

(5) The Department of Insurance.

(6) Local and state law enforcement agencies.

(7) Employers, as defined in Section 3300 of the Labor Code, who are self-insured for workers' compensation and doing business in the state.

(h) Basic claims information including trends of payments by type of claim and other claim information that is generally provided in a closed claim study.

(i) A summary of the bureau's activities with respect to the reduction pursuant to Section 1871.4 of fraudulent denials and payments of compensation.

(j) The number and types of cases investigated and prosecuted with funds specified in Section 1872.83.

(k) The number and types of health insurance fraud cases investigated and prosecuted with funds specified in Section 1872.85.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

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